Tuberculosis Contact Assessment Form

Details of Source case	
Source case TB # Smear positive ☐ yes ☐ no Culture positive ☐ yes ☐ no	Exposure Case Event/Location: _____ _____ Date last exposed: _____ (YYYY-MM-DD)

DEMOGRAPHICS

Family name	First name Second name		PHIN MHSC#
Address	City /town		Postal code
Gender ☐ Male ☐ Female	Date of birth (yyyy/mm/dd)	First Nations Status: ☐ Status Indian registered ☐ Metis ☐ Inuit ☐ other aboriginal	Band of origin
Home /residential phone number ☐	Business phone number ☐		Cell phone number ☐
Occupation	Primary Language	If primary language not English, speaks and understand English? ☐ yes ☐ no	
Name of family physician (if you have one)	Birth country or Birth province	Date arrived in Canada (yyyy/mm/dd)	

ENCOUNTER DETAILS: SIGNS AND SYMPTOMS

Have you experienced any of the following symptoms in the past three months?

	YES	NO	Date started	How long did it last?		YES	NO	Date started	How long did it last?
Pain with breathing	☐	☐			Night Sweats	☐	☐		
Cough If cough, productive?	☐ ☐	☐ ☐			Fatigue	☐	☐		
Hemoptysis	☐	☐			Lymphadenopathy	☐	☐		
Weight loss	☐	☐			Other	☐	☐		
Fever	☐	☐			Asymptomatic for TB	☐	☐		

ENCOUNTER DETAILS: TUBERCULIN SKIN TEST

Have you ever had TB? ☐ yes ☐ no If yes, When (yyyy/mm): _____Where:_____	Have you ever taken medications for TB? ☐ yes ☐ no
Have you ever had a positive tuberculin skin test? ☐ yes ☐ no If yes, When (yyyy/mm): _____Where:_____	Client refuses Tuberculin skin test? ☐ yes ☐ no

Do you have any allergies? ☐ yes ☐ no If yes, please describe:

Have you had a major viral infection or live-virus vaccination in the past 6 weeks? ☐ yes ☐ no
(E.g., mumps, measles, rubella, yellow fever, chickenpox)

ENCOUNTER DETAILS: BCG

Previous BCG? ☐ yes ☐ no ☐ unknown If yes, Date (yyyy) _____ Province/country BCG given: _____

CONSENT	Informed consent provided by client? ☐ yes ☐ no	Consent to share information with physician ? ☐ yes ☐ no (including subsequent test results)

Name of nurse completing initial assessment (please print and sign):	Date of initial assessment:

PARENT/LEGAL GUARDIAN CONSENT (only complete for children and others as appropriate)

I have read and understood the attached letter and fact sheet on tuberculosis. ☐ yes ☐ no

☐ **YES I do consent** for the above named child to receive tuberculosis skin testing	☐ **NO I do not consent** for the above named child to receive tuberculosis skin testing

Signature of legal guardian Date

Name:	Birth date:	PHIN:	MFRN:	Male ☐ Female ☐

ENCOUNTER DETAILS: TUBERCULIN SKIN TEST

Date TST planted (yyyy/mm/dd)	Product	Lot #	Manufacturer	Test Strength (Dose and Route)	Comments (Site)	Administered by (Nurse signature)

Any problems with TST administration? ☐ yes ☐ no Specify:

Date TST read (yyyy/mm/dd)	Measurement (mm)	Signature
Date TST read (yyyy/mm/dd)	Measurement (mm)	Signature

Any problems with TST reading ☐ yes ☐ no Specify:

FOLLOW – UP choose only one:

Repeat TST >= 8 weeks post exposure only ☐ After (yyyy/mm/dd): _____	Referred for Window Period Prophylaxis ☐
Referred for chest x-ray only ☐	Discontinue Window Period Prophylaxis ☐
Chest x-ray and sputum only ☐	No follow-up required (no further testing) ☐
Chest x-ray, sputum and repeat TST only ☐	Other follow-up required ☐ Specify:
Chest x-ray requisition given: ☐ yes ☐ no Date (yy/mm/dd) Signature	Sputum testing requisitions & containers given: ☐ yes ☐ no Date (yy/mm/dd) Signature

EPISODE: RISK FACTORS

MEDICAL RISKS	YES	NO	UNKNOWN	NOT ASKED
End stage renal disease				
Long-term (>= month) corticosteroid use				
Tumour necrosis factor alpha inhibitors				
Diagnosis of cancer within last 5 years Specify type:				
Transplant related immunosuppression				
Diabetes – all				
Weight <90% ideal body weight; BMI <20				
Abnormal CXR - granuloma				
Abnormal CXR - Fibronodular disease				
Silicosis				
HIV Status:_____ Date:_____				
Smoking (indicate amount)				
History of not completing therapy/risk of treatment failure				
OTHER RISKS				
Travel to TB Endemic country or community in past 2 years: Location: _____ Duration: _____				
Pregnancy EDC:_____				

NOTES

DATE(yymmdd)		SIGNATURE